Office of Administration

Commissioner's Office

"Request for Preauthorization for Other Services"

Program: **Alternatives to Abortion**
Contractor: Nurses for Newborns
Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

Client N [redacted] *Date Enrolled:* 8/9/16

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
	Car Payment	$300	Mom is out of work at this time. No family support.
AMOUNT TO BE REIMBURSED		$300	

Please return to Alternatives to Abortion Program Manager, State of Missouri – Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to emily.kraft@oa.mo.gov by the Contractor only!
Thank you.

Authorized person requesting purchase: [signature] 2/8/17

Approved for purchase: Emily Kraft Date 2/9/17

Purchase denied: _____ Date _____

Reason for denying purchase: _____

ALTERNATIVES TO ABORTION PROGRAM
Assistance Request

This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.

DATE: 2 / 1 / 17 CLIENT NAME [redacted]

The above named client is requesting assistance through NFN's ATA Program for the following:

____ **Rent**
(if new request, a W-9 and Lease MUST accompany this form)

____ **Utility**
(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

__✓__ **Transportation**
(if new request, no additional information is needed; if repeat request for gas card ONLY, please provide receipts)

____ **Other**
(Pre-Authorization Request and documentation of the bill/invoice/etc. to be paid MUST accompany this form)

Landlord/Utility/Other NAME: Lou Fusz

BILL TOTAL: $ 300 AMOUNT YOU ARE PAYING: $ 0 AMOUNT REQUESTED: $ 300

OTHER RESOURCES ATTEMPTED FOR ASSISTANCE (must list at least three):

1. _____ Agency Representative: _____
2. _____ Agency Representative: _____
3. _____ Agency Representative: _____

I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a ***Budget Form*** *and* ***Indiyidualized Pregnancy Continuation Plan*** *(IPCP) with my nurse in order to ensure my ability to pay t*

[redacted]

(client signature) 2/1/17 (date)

(RN signature) 2/1/17 (date)

IPCP Completed/Submitted: _____ (initial) Budget Form Completed: _____ (initia

Date Received: _____ Date Pledged/Submitted for Payment: _____

Lou Fusz Auto Credit
Corporate Office
10950 Page Blvd
St. Louis, MO 63132
Fax: 314-595-2916

FACSIMILE TRANSMITTAL

To: Nurses for Newborns - Jennifer Cornell	**Fax #:** 314-448-4004
From: CAT Lou Fusz BHPH	**Fax #:** 314-595-2700
Pages: [#] Inclusive: 3	**Date:**
Re: [redacted]	

Account Information

& Address

lou fusz buick GMC

Attn BHPH

10950 Page Blvd

St. louis, MO 63132

Address

any question don't hesitate to call

Cat~ 314-595-2988

Customer Payment Entry

Contract Number [redacted] ACTIVE [redacted] OFFICE/GENERAL [redacted]

[redacted]

PDI Expired

[redacted]

Due Date/Days Past Due	02/10/17		Payment Frequency	Monthly
Payment Due	.00		Payment Amount	299.94
Partial Payment Credit	-.36		Contract No. Payments	51
Late Charge Due	60.00	15	Payments Remaining	37
Return Check Charge			Contract Balance	8431.00
			Contract Payoff	8530.96
Total Due	59.64		Payoff Quote	
Total Received				
Late Charge Received			Late Charge Credit	
			Interest Due	99.96

Function*

ATTN.

Jennifer Corwell

Concerning:

[redacted]